BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LESLIE KAYE CORONA** **1172 S Main St Apt 150** **Salinas, CA 93901** **Registered Nurse License No. 456190** RESPONDENT	Case No. 2012-333 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about December 1, 2011, Complainant Louise R. Bailey, M.Ed.,RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2012-333 against Leslie Kaye Corona (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about August 31, 1990, the Board of Registered Nursing (Board) issued Registered Nurse License No. 456190 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2012, unless renewed.

3. On or about December 1, 2011, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2012-333, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record which, pursuant to Business and Professions Code section 136 and/Title 16, California Code of Regulation, section 1409.1, is required to be reported and maintained with the Board, which was and is:

1172 S Main St Apt 150

Salinas, CA 93901.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. On or about December 9, 2011, the signed Certified Mail Receipt was returned to our office indicating a delivery date of December 3, 2011.

6. Business and Professions Code section 2764 states:

The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with an investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license.

7. Government Code section 11506 states, in pertinent part:

(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

8. Respondent failed to file a Notice of Defense within 15 days after service of the Accusation upon her, and therefore waived her right to a hearing on the merits of Accusation No. 2012-333.

9. California Government Code section 11520 states, in pertinent part:

(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

10. Pursuant to its authority under Government Code section 11520, the Board after having reviewed the proof of service dated December 1, 2011, signed by Kami Pratab, finds Respondent is in default. The Board will take action without further hearing and, based on Accusation No. 2012-333 and the documents contained in Default Decision Investigatory Evidence Packet in this matter which includes:

Exhibit 1: Pleadings offered for jurisdictional purposes; Accusation No. 2012-333, Statement to Respondent, Notice of Defense (two blank copies), Request for Discovery and Discovery Statutes (Government Code sections 11507.5, 11507.6 and 11507.7), proof of service; and if applicable, mail receipt or copy of returned mail envelopes;

Exhibit 2: License History Certification for Leslie Kaye Corona, Registered Nurse License No. 456190;

Exhibit 3: Affidavit of Kami Pratab;

Exhibit 4: Certification of costs by Board for investigation and enforcement in Case No. 2012-333;

Exhibit 5: Declaration of costs by Office of the Attorney General for prosecution of Case No. 2012-333.

The Board finds that the charges and allegations in Accusation No. 2012-333 are separately and severally true and correct by clear and convincing evidence.

11. Taking official notice of Certification of Board Costs and the Declaration of Costs by the Office of the Attorney General contained in the Default Decision Investigatory Evidence Packet, pursuant to the Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement in connection with the Accusation are $6,466.00 as of January 12, 2012.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Leslie Kaye Corona has subjected her following license(s) to discipline:

a. Registered Nurse License No. 456190

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's license(s) based upon the following violations alleged in the Accusation, which are supported by the evidence contained in the Default Decision Investigatory Evidence Packet in this case.

a. Violation of Business and Professions Code section 2761(a)(1) - Unprofessional Conduct, Gross Negligence.

b. Violation of Business and Professions Code section 2762(a) - Obtaining or possessing controlled substances without a prescription.

c. Violation of Business and Professions Code section 2762(b) - Use of controlled substance or alcohol to an extent or in a manner dangerous or injurious to oneself and others.

d. Violation of Business and Professions Code section 2762(e) - Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to a controlled substance.

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ORDER

IT IS SO ORDERED that Registered Nurse License No. 456190, heretofore issued to Respondent Leslie KayeCorona, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on August 10, 2012.

It is so ORDERED July 13, 2012.

Board of Registered Nursing
Department of Consumer Affairs
State of California

Attachment:

Exhibit A: Accusation No. 2012-333

Exhibit A

Accusation No. 2012-333

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LESLIE KAYE CORONA** **1172 S. Main Street, Apt. 150** **Salinas, CA 93901** **Registered Nurse License No. 456190** Respondent.	Case No. 2012-333 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1990, the Board of Registered Nursing issued Registered Nurse License Number 456190 to Leslie Kaye Corona (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought in this Accusation and will expire on August 31, 2012, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 118, subdivision (b), of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as

defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

10. "Dilaudid" (trade name "Hydromorphone") is a very potent centrally-acting analgesic of the opiate class, used to relieve moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(K), and a dangerous drug pursuant to Business and Professions Code section 4022.

11. "Demerol" (trade name "Pethidine or Meperidine Hydrochloride") is a narcotic analgesic used to treat moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(17), and a dangerous drug pursuant to Business and Professions Code section 4022.

12. "MS Contin" (brand name "Morphine Sulfate (MS)") is a central nervous system depressant and a systemic narcotic and analgesic used to treat moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(m), and a dangerous drug pursuant to Business and Professions Code section 4022.

13. "Valium" (brand name "Diazepam") is used to relieve anxiety, muscle spasms, seizures, and to control agitation caused by alcohol withdrawal. It is a Schedule IV controlled

substance pursuant to Health and Safety Code section 11057, subdivision (d)(9), and a dangerous drug pursuant to Business and Professions Code section 4022.

14. "Vicodin" is used to relieve moderate to severe pain. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug pursuant to Business and Professions Code section 4022.

15. "Pyxis" is a computerized management, storage, and medication dispensing system/machine utilized in some hospital settings. Access to the system is made via a password and/or bio-identification.

FIRST CAUSE FOR DISCIPLINE

(Grossly Incorrect and/or Grossly Inconsistent Entries in Patient Records)

16. Respondent has subjected her license to disciplinary action under section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in section (e), as follows:

On or about September 1, 2008, through November 21, 2008, while employed as a registered nurse at Salinas Valley Memorial Healthcare System/Hospital, Respondent made grossly incorrect or grossly inconsistent entries in hospital and patient records pertaining to a controlled substance in the following respects:

A. **Patient 1**[1] had physician's orders for 4 mg of Morphine dated November 20, 2008, time-stamped 9:45 p.m. and 11:37 p.m. and November 21, 2008, at 8:08 p.m. and 12:50 a.m. Registered nurses in the Emergency Department administered 4 mg of Morphine to Patient 1 on November 20, 2008, at 9:47 p.m. and 11:37 p.m., and November 21, 2008 at 12:30 a.m.

1. On November 21, 2008, at 12:47 a.m., Respondent withdrew from Pyxis one Morphine 4 mg syringe for Patient 1, via an override transaction. There was no physician's order for an additional administration of Morphine for Patient 1. The Pyxis report shows that Respondent wasted 4 mg of Morphine in the presence of another registered nurse on November 21, 2008, at 12:50 a.m. Respondent did not document the administration of Morphine or

[1] The patient names will be released to Respondent pursuant to a request for discovery.

otherwise account for the wastage of the Morphine in the Medication Administration Record (MAR).

B. **Patient 2** had a physician's order dated September 1, 2008, time-stamped 4:10 p.m. for 4-8 mg of Morphine every two hours as need for pain and for 6-12 mg of Morphine. Registered nurses in the Emergency Department administered 4 mg of Morphine to Patient 2 on September 1, 2008, at 1:46 p.m. and 2 mg of Morphine at 2:34 p.m. Patient 2 had a physician's order dated September 1, 2008, at 4:08 p.m. for a 10 mg tablet of Diazepam twice daily. Patient 2 had a physician's order dated September 1, 2008, at 7:57 p.m. for 1-2 mg of Dilaudid every four hours as needed for pain.

1. On September 1, 2008, at 4:23 p.m., Respondent withdrew from Pyxis one 10 mg syringe of Morphine for Patient 2. The Pyxis report shows that Respondent administered 8 mg of Morphine and wasted 2 mg of Morphine in the presence of another registered nurse on September 1, 2007, at 7:07 p.m. Respondent failed to document the administration or wastage of the Morphine in the MAR or otherwise account for the disposition of 8 mg syringe of Morphine. In addition, Respondent failed to complete pre and post pain assessments.

2. On September 1, 2008, at 7:22 p.m., Respondent withdrew from Pyxis one 10 mg syringe of Morphine for Patient 2. Respondent failed to document the administration, wastage or otherwise account for the disposition of 10 mg syringe of Morphine.

3. On September 1, 2008, at 7:22 p.m., Respondent withdrew from Pyxis one 2 mg syringe of Morphine for Patient 2. Respondent failed to document the administration, wastage or otherwise account for the disposition of the 2 mg syringe of Morphine

4. On September 1, 2008, at 7:31 p.m., Respondent withdrew from Pyxis two 5 mg tablets of Diazepam for Patient 2. Respondent failed to document the administration, wastage or otherwise account for the disposition of the two 5 mg tablets of Diazepam.

5. On September 1, 2008, at 8:20 p.m., Respondent withdrew from Pyxis 4 mg of Dilaudid for Patient 2. At 8:50 p.m., Respondent wasted 3 mg of Dilaudid in the presence of another registered nurse. Respondent failed to document the administration, wastage or otherwise account for the disposition of 1 mg of Dilaudid.

C. **Patient 3** had a physician's order dated September 1, 2008, time-stamped 9:32 a.m. for 1 mg of Dilaudid every two hours as needed for pain.

1. On September 1, 2008, at 3:13 p.m., Respondent withdrew from Pyxis one 4 mg syringe of Dilaudid for Patient 3. Respondent wasted 3 mg of Dilaudid in the presence of another registered nurse at 3:25 p.m. Respondent failed to document the administration, wastage or otherwise account for the disposition of 1 mg of Dilaudid.

2. On September 1, 2008, at 4:48 p.m., Respondent withdrew from Pyxis one 4 mg syringe of Dilaudid for Patient 3. Respondent wasted 3 mg of Dilaudid in the presence of another registered nurse at 7:04 p.m. Respondent failed to document the administration, wastage or otherwise account for the disposition of 1 mg of Dilaudid.

3. On September 1, 2008, at 9:04 p.m., Respondent withdrew from Pyxis one 4 mg syringe of dilaudid for Patient 3. Respondent wasted 3 mg of Dilaudid in the presence of another registered nurse at 9:54 p.m. Respondent failed to document the administration, wastage or otherwise account for the disposition of 1 mg of Dilaudid.

D. **Patient 4** had a physician's order dated November 15, 2008, time-stamped 5:21 p.m. for 5 mg of Dilaudid (frequency is illegible) as need for pain and at 8:00 p.m. for 1 mg of Dilaudid (frequency is illegible) as needed for pain.

1. On November 15, 2008, at 5:23 p.m., Respondent withdrew from Pyxis one 4 mg syringe of Dilaudid for Patient 4. Respondent wasted 3.5 mg of Dilaudid in the presence of another registered nurse. Respondent failed to document the administration, wastage or otherwise account for the disposition of .5 mg of Dilaudid.

2. On November 15, 2008, at 8:02 p.m., Respondent withdrew from Pyxis one 4 mg syringe of Dilaudid for Patient 4. Respondent wasted 3 mg of Dilaudid in the presence of another registered nurse. Respondent failed to document the administration, wastage or otherwise account for the disposition of 1 mg of Dilaudid.

E. **Patient 5** had a physician's order dated November 15, 2008, time-stamped 3:10 p.m. for an unspecified amount of Demerol for Patient 5. Patient 5 was discharged from the Emergency Department at 3:50 p.m.

1. On November 15, 2008, at 3:11 p.m., Respondent withdrew from Pyxis one 50 mg syringe of Demerol for Patient 5. Respondent failed to document the administration, wastage or otherwise account for the disposition of 50 mg of Demerol.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Use of Controlled Substance)

17. Respondent has subjected her license to disciplinary action under section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in section 2762, subdivision (e), in that on or about December, 2007 through November, 2008, while employed as a registered nurse at Salinas Valley memorial Hospital, in Freedom, California, Respondent used controlled substances as follows:

A. On or about December 2, 2008, Respondent admitted to obtaining controlled substances for patients, administering the prescribed dosage to the patients, charting the wastage of controlled substances, not wasting the controlled substance, but, personally (while on duty) utilizing the controlled substance that she falsely charted as having wasted.. Respondent was terminated from her position on December 3, 2008.

B. On or about November 21, 2008, at 12:47 a.m., Respondent submitted to a urine test. Respondent tested positive for Morphine, Hydrocodone, and Dilaudid.

C. On or about December 4, 2008, Respondent entered the Board's Drug Diversion Program. On January 27, 2010, Respondent admitted that she had relapsed with Vicodin. Respondent was terminated from the Diversion Program as a public safety risk on March 30, 2010.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Obtain Controlled Substance)

18. Respondent has subjected her license to disciplinary action under section 2761, subdivision (a) on the grounds of unprofessional conduct, as defined in section 2762, subdivision (b) in that she unlawfully obtained and/or possessed Morphine, Hydrocodone, Dilaudid, and Vicodin without a physician's prescription as set forth in paragraph 17, above.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence)

19. Respondent has subjected her license to disciplinary action under section 2761, subdivision (a)(1) on the grounds of gross negligence based on the acts and/or omissions as set forth in paragraph 16, above.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Comply with Rehabilitation Program)

20. Respondent has subjected her license to discipline under Code section 2770.11, in that she was deemed a "public safety risk" and terminated from the Board's Rehabilitation Program on March 30, 2010. Respondent failed to comply with the Board's Rehabilitation Program as follows:

a. Respondent failed to call in for biological fluid testing on March 9, 2009; April 15, 2009; June 21, 2009; and March 19 and 28, 2010.

b. Respondent admitted to relapsing on Vicodin on January 27, 2010.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 456190, issued to Leslie Kaye Corona;

2. Ordering Leslie Kaye Corona to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: December 1, 2011

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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